STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

APPLICATION FOR LICENSURE

PHYSICIAN ASSISTANT

DOPL-AP-078 REV 06/28/2002

APPLICATION INSTRUCTIONS AND INFORMATION

General Statement: The Division desires to provide courteous and timely service to all applicants for licensure. To maximize its efficiency and level of service, the Division will process complete applications only. **A complete application includes all applicable supporting documents and fees.** The fees are for processing your application and will not be refunded. Failure to complete the application and supply necessary information will delay processing and may result in denial of licensure. Please read all instructions carefully.

Address of Record: The address listed on the application will be your address of record. All correspondence from the Division will be sent to that address. It is your responsibility to directly notify the Division of any change in address. Also, please note, the address of record is public information, available upon request and via the Internet. You may choose to use a business address or a post office box for your address of record rather than your home address.

Social Security Number: Your social security number is classified as a private record pursuant to Title 63, Chapter 2, Utah Government Records Access and Management Act (GRAMA). It is used as an individual identifier for our licensing database and for purposes of the child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements the requirements of 42 U.S.C. 666(a)(13). An application that does not include a social security number is incomplete and cannot be processed.

SUPPORTING DOCUMENTS AND FEES:

1. Submit a "Certification of Completion of Physician Assistant Education" form (attached to this application) completed by an official representative of your accredited physician assistant program.

2. Using the "NCCPA Request and Authorization for Release of Information" form (attached to this application), submit a National Commission on Certification of Physician Assistant Certificate to document passing the NCCPA examination – unless you are applying for a temporary license.

3. Submit the original letter from Experior documenting your passing score on the Utah Physician Assistant Law and Rules Examination.

4. If you are applying by endorsement, use the "Request for Verification of License" form (attached to this application) to obtain verification of licensure from a state in which you are currently licensed as a physician assistant.

   Request that the verifying state(s) complete the form(s) and mail or fax them directly to the Division or return them to you for submission with your application.

5. Submit a **$130.00** non-refundable application processing fee for a physician assistant license.

6. If you are applying for a **Utah controlled substance license**, additionally submit the following:

   - The original letter from Experior documenting your passing score on the Controlled Substances Law and Examination.

   - An additional $90.00 non-refundable application processing fee for a controlled substance license.

     Note: The total fees for a physician assistant license and a Utah controlled substance license are $220.00.

7. If you are applying for a **temporary license**, additionally submit the following:

   - A "Physician Assistant Temporary License Request" form (attached to this application) – if you have met all requirements except passing the NCCPA Examination. (See the "Additional Important Information" section below.)

   - An additional $50.00 non-refundable application processing fee for a physician assistant temporary license.

     Note: The total fees for a physician assistant license and a temporary physician assistant license are $180.00.

     The total fees for a physician assistant license and a temporary physician assistant license and a Utah controlled substance license are $270.00.

ADDITIONAL IMPORTANT INFORMATION:

1. **Law and Rules Exams:** All applicants for licensure must pass the Utah Physician Assistant Law and Rule Examination. Contact Experior at the address and telephone number below to register for the examination.

   Experior, 5486 South 1900 West, Suite C, Taylorsville, Utah 84118, (801) 355-5009

   The Controlled Substances Law Examination is also administered by Experior. For registration and fee information, contact them directly at the address and telephone number listed above.

   You may also purchase a study guide(s) from Experior, which has been prepared to assist candidates taking the exams.

   In addition, the following applicable laws and rules are available on the Internet at www.dopl.utah.gov or they can be purchased from Experior at the address and telephone number listed above.

   - Division of Occupational & Professional Licensing Act
   - General Rules of the Division of Occupational and Professional Licensing
   - Utah Physician Assistant Practice Act
   - Utah Physician Assistant Practice Act Rules
   - Utah Controlled Substances Act
   - Controlled Substance Act Rules of the Division of Occupational and Professional Licensing
   - Health Care Providers Immunity from Liability Act

2. **Examination Fees:** There are separate fees for all examinations. It is the responsibility of the applicant to submit the fees directly to the testing agency.

3. **Delegation of Services Agreement:** A "Delegation of Services Agreement" is to be maintained at each of your Utah practice sites and must be available to the Division of Occupational and Professional Licensing upon request. **Do not submit them with your application for licensure.** The agreements contain written criteria jointly developed by you and your supervising physician and substitute supervising physicians that permit you, working under the direction or review of the supervising physicians, to assist in the management of illnesses and injuries common to the physician's scope of practice. A "Delegation of Services Agreement" form is included with this application for your convenience.

4. **Temporary License:** A temporary license will only be issued to an applicant who has never taken the NCCPA certification examination and who otherwise meets all licensure requirements.

A temporary license is valid from its date of issuance until the earlier of the following dates:

- 10 days after receiving the test results of the first scheduled NCCPA examination following issuance of the temporary license; or
- failure to take the first scheduled NCCPA examination following issuance of the temporary license

A Physician Assistant holding a temporary license may work:

- only under the direct supervision of an approved supervising or substitute supervising physician with the physician physically present on site and immediately available for consultation;
- only with 100% review and countersigning of patient charts; and
- only in accordance with a Delegation of Services Agreement.

5. **Controlled Substance License:** You must hold a Utah controlled substance license and a DEA registration to administer, possess, or prescribe a controlled substance in your practice in Utah. You must obtain your own controlled substance license and DEA registration. You may not use your supervising physicians' controlled substance licenses or DEA registrations.

6. **DEA Registration**: For DEA registration information, contact the Drug Enforcement Administration at (800) 326-6900.

7. **License Renewal:** All physician assistant licenses expire May 31 of each even-numbered year.

   Unlike many other states, Utah's license renewal schedule **is not** based on the licensee's date of initial licensure. Under Utah's renewal system, all licenses in each profession expire as a group on the same day every two years. Therefore, the length of a licensee's first renewal cycle depends on how far into the current renewal cycle initial licensure was obtained. Each renewal cycle thereafter is for a full two years.

   Additionally, the fee paid with this application for licensure is an application processing fee only. It does not include a renewal fee. Each licensee is responsible to renew licensure **PRIOR** to the expiration date shown on the current license. Renewal information is disseminated to each licensee at the licensee's last known address, as provided to the Division, approximately three months prior to the expiration date shown on the license.

8. **Renewal Requirements / Continuing Education:** In order to renew your license you must complete at least 40 hours of Category 1 ACCME continuing education in each two-year license renewal cycle.

9. **Updating Address Information:** It is your responsibility to maintain a current address with the Division. If your address is incorrect, you will not receive renewal notices or other correspondence.

10. **Current Documents:** Applications, statutes, and rules may change from time to time. If you have not recently obtained any of these documents, you may want to contact the Division or visit our Internet site to verify that you have current versions.

11. **Payments:** Make licensure fees payable to "DOPL."

12. **Mail Complete Application to:**

By U.S. Mail
Division of Occupational & Professional Licensing
P.O. Box 146741
Salt Lake City, Utah 84114-6741

By Delivery or Express Mail
Division of Occupational & Professional Licensing
160 East 300 South, 1st Floor Lobby
Salt Lake City, Utah 84111

13. **Telephone Numbers:** (801) 530-6628

(866) ASK-DOPL – Toll-free in Utah
(866) 275-3675

14. **Fax Number:** (801) 530-6511

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APPLICATION FOR LICENSE or CERTIFICATE or REGISTRATION

GENERAL INFORMATION

License/Certificate/Registration Applying For: _____

Social Security Number: _____

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Gender (Male or Female): _____ Date of Birth: _____

Have You Ever Held A Utah License Before? Yes_____ No_____

If Yes, Name of Profession: _____

If Yes, License Number: _____

PUBLIC MAILING ADDRESS

Street: _____

City: _____ State: _____ Zip: _____

County: _____

Telephone: (_____)_____

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved: _____

Approved By: _____

Date License/Certificate Denied: _____

Denied By: _____

Reason For Denial/Other Comments: _____

APPLICATION FOR (check all that apply):

_____ Physician Assistant License

_____ Physician Assistant Temporary License

_____ Controlled Substance License

PHYSICIAN ASSISTANT SCHOOL (Use additional sheets if necessary):

Name: _____ Dates Attended: _____ To _____

Location: _____

Degree Received: _____ Date of Graduation: _____

PROFESSIONAL EXAMINATION REQUIREMENT:

Answer "**yes**" or "**no**."

_____NCCPA, Date(s) Taken: _____

_____Physician Assistant Law and Rules Examination, Date(s) Taken: _____

_____Controlled Substances Law Examination, Date(s) Taken: _____

LICENSES:

List all licenses, registrations, or certifications issued by any state which you now hold or have ever held in any health care profession. Use additional sheets if necessary.

Issuing State: _____

Profession: _____

License Number: _____

Effective Date: _____

License Status: _____

Issuing State: _____

Profession: _____

License Number: _____

Effective Date: _____

License Status: _____

Issuing State: _____

Profession: _____

License Number: _____

Effective Date: _____

License Status: _____

RECORD OF PROFESSIONAL EXPERIENCE:

Account for all time periods since graduation from PA school. Use additional sheets if necessary.

Employer: _____

Address: _____

Dates of Employment: From _____/_____ To _____/_____ Telephone: _____

Contact Person: _____

Practice Type and Specialty: _____

_____

Employer: _____

Address: _____

Dates of Employment: From _____/_____ To _____/_____ Telephone: _____

Contact Person: _____

Practice Type and Specialty: _____

_____

Employer: _____

Address: _____

Dates of Employment: From _____/_____ To _____/_____ Telephone: _____

Contact Person: _____

Practice Type and Specialty: _____

_____

IF APPLYING FOR A CONTROLLED SUBSTANCE LICENSE:

I hereby agree to comply with the laws of Utah relating to the Controlled Substances Act and Rules.

Signature of Applicant: _____

Date of Signature: _____

IF PRACTICING AS A PHYSICIAN ASSISTANT IN UTAH:

Complete the following for each of your practice sites. Use additional sheets if necessary.

Supervising Physician's Name: _____

Supervising Physician's Utah License Number: _____

Specialty: _____

Number of PAs supervised (including the applicant): _____ Number of FTE PAs: _____

Practice Site(s): _____

_____

Type of Practice: _____

Percent of Direct Supervision: _____

Substitute Supervising Physician's Name: _____

Specialty: _____

AFFIDAVIT:

I declare under penalty of perjury as follows:

I will be practicing as a physician assistant in Utah. I have completed a "Delegation of Services Agreement" with my supervising physician and have reviewed the agreement with each of my substitute supervising physicians.

A copy of the agreement is on file at each of my Utah practice sites and is available to the Division upon request.

The agreement defines the working relationship and delegation of duties between me and my supervising physician and includes all of the following: the prescribing of controlled substances; the degree and means of supervision; the frequency and mechanism of chart review; procedures addressing situations outside my scope of practice; and procedures for providing backup for me in emergency situations. The written criteria were jointly developed by me and my supervising physician and by me and any substitute supervising physicians. The agreement permits me to work under the direction or review of my supervising physician(s) to assist in the management of illnesses and injuries common to the physician's scope of practice.

Signature of Physician Assistant Applicant: _____

Date of Signature: _____

Signature of Supervising Physician: _____

Date of Signature: _____

IF NOT PRACTICING AS A PHYSICIAN ASSISTANT IN UTAH:

I declare under penalty of perjury as follows:

I will not be practicing as a Physician Assistant in Utah at this time. I agree to immediately complete a "Delegation of Services Agreement" consistent with Utah law before I begin to practice within the state. Said agreement(s) will be on file at my Utah practice site(s).

Signature of Applicant: _____

Date of Signature: _____

PHYSICIAN ASSISTANT
QUALIFYING QUESTIONNAIRE

Answer "**yes**" or "**no**" for each question. Do not leave any question blank.

1. _____ Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?

2. _____ Have you ever been denied the right to sit for a licensure examination?

3. _____ Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

4. _____ Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any professional licensing agency or criminal or administrative jurisdiction?

5. _____ Are you currently under investigation or is any disciplinary action pending against you now by any professional licensing agency?

6. _____ Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

7. _____ Have you ever been permitted to resign or surrender hospital or other health care facility privileges while under investigation or while action was pending against you by any health care profession licensing agency, hospital, or other health care facility or criminal or administrative jurisdiction?

8. _____ Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?

9. _____ Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

10. _____ Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any health care profession licensing agency, hospital, or other health care facility or criminal or administrative jurisdiction?

(Questions continue on following page.)

11. _____ Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?

12. _____ Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?

13. _____ Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility or criminal or administrative jurisdiction?

14. _____ Is any action pending against you now by either the federal Drug Enforcement Administration or any state drug enforcement agency?

15. _____ Have you been named as a defendant in a malpractice suit?

If you answered "yes" to question 15 above, for each malpractice suit filed against your license, supply the date, status, disposition, amount of settlement, and a detailed description including your relationship to the patient and your role in the case.

16. _____ Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?

17. _____ Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?

18. _____ If you are licensed in the health care profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?

19. _____ Are you currently using or have you recently (within 90 days) used any drugs (including recreational drugs) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?

(Questions continue on following page.)

20. _____ Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which you have not successfully completed or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?

21. _____ Have you been arrested for or charged with a misdemeanor or felony charge in any jurisdiction during the last 10 years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.

22. _____ Have you ever pled guilty to, no contest to, or been convicted of any felony or misdemeanor in any jurisdiction?

If you answered "yes" to question 21 or 22 above, you must include with your application a copy of the police report, court docket, and any probation/parole officer report for EACH and EVERY arrest and/or conviction within the past ten years.

23. _____ Have you ever been involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?

24. _____ Have you ever been terminated from a position because of drug use or abuse?

25. _____ Have you ever been incarcerated for any reason in any federal, state or county correctional facility?

If you answered "yes" to any of the above questions, please enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

A "yes" answer does not necessarily mean that you will not be granted a license; however, the Division may request additional documentation if the information submitted is insufficient.

AFFIDAVIT and RELEASE AUTHORIZATION

I am the applicant described and identified in this application for licensure, certification, or registration in the State of Utah.

I am qualified in all respects for the license, certificate, or registration for which I am applying in this application.

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and, discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division in conjunction with this application or its supporting documents meet the same standard as set forth above.

I understand that it is unlawful and punishable as a class A misdemeanor to apply for or obtain a license or to otherwise deal with the Division or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

I understand that this application will be classified as a public record and will be available for inspection by the public, except with regard to the release of information which is classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of Applicant: _____

Date of Signature: _____

Printed Name of Applicant: _____

Utah Division of Occupational and Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741

CERTIFICATION OF COMPLETION OF PHYSICIAN ASSISTANT EDUCATION

TO BE COMPLETED BY THE APPLICANT:

Request that the official representative of your accredited physician assistant program complete this form and return it to you for submission with your application.

Applicant Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Graduation: _____

TO BE COMPLETED BY THE ACCREDITED PHYSICIAN ASSISTANT PROGRAM OFFICIAL REPRESENTATIVE:

Name of Institution: _____

Location of Institution: _____

Telephone of Institution: _____

Date of Accreditation: _____

Accredited By: _____

I attest that the above named applicant attended this physician assistant program from _____/_____ to _____/_____ and graduated on _____/_____.

Signature of Official Program Representative: _____

Title: _____

Signed and the school seal affixed this _____ day of _____, 20_____.

(School Seal)

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Utah Division of Occupational and Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
FAX: 801-530-6511

REQUEST FOR VERIFICATION OF LICENSE

TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form and submit it to a state in which you are currently licensed as a physician assistant. Request that the verifying state complete the form and mail or fax it directly to the Division or return it to you for submission with your application.

Applicant Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

I am requesting licensure in the state of Utah as a/an _____

I am/have been licensed in your state under the name _____

My social security number is _____

My date of birth is _____

My license number in your state is/was _____

I have enclosed the necessary license verification fee in the amount of $ _____

Signature of Applicant: _____

TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and mail or fax it directly to the Division or place the completed form in a sealed envelope and provide it to the applicant in person or by mail. The applicant will include the verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: _____

Name of Licensee (as it appears in verifying state's records): _____

Classification of License Issued: _____

License Number: _____

Current Status: _____

Original Date of Licensure: _____

Expiration Date: _____

Continuously Licensed:

_____Yes _____No, please explain: _____

Licensed By:

_____Exam, Type: _____ Date: _____

_____Endorsement: from what state? _____

Examination Scores: _____

Education Required for Licensure: _____

Disciplinary Action or Pending Disciplinary Action:

_____No _____Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: _____

Title: _____

Agency: _____

Date: _____

(SEAL)

Utah Division of Occupational and Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741

PHYSICIAN ASSISTANT
TEMPORARY LICENSE REQUEST

TO BE COMPLETED BY THE APPLICANT:

Name: _____

Address: _____

Telephone: _____ Date Taking Certifying Exam: _____

Supervising Physician: _____

Address: _____

Telephone: _____ Date Employment to Begin: _____

Clinic Location: _____

Address: _____

Telephone: _____

I hereby certify that I will not practice until I have been granted a temporary license. Once the temporary license has been issued, I will only practice under the direct supervision of my supervising physician or substitute supervising physician.

Signature of Applicant: _____

Date of Signature: _____

TO BE COMPLETED BY SUPERVISING PHYSICIAN:

Name: _____

Address: _____

Telephone: _____ Utah License Number: _____

Signature of Supervisor: _____ Date of Signature: _____

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PHYSICIAN ASSISTANT
DELEGATION OF SERVICES AGREEMENT

A Delegation of Services Agreement is to be maintained at each practice site and is to be available to the Division upon request. It consists of written criteria jointly developed by a physician assistant's supervising physician and any substitute supervising physicians and the physician assistant that permits a physician assistant, working under the direction or review of the supervising physicians, to assist in the management of illnesses and injuries common to the physician's scope of practice.

The following information must be legible. Use additional sheets if necessary.

DO NOT SUBMIT YOUR DELEGATION OF SERVICES AGREEMENTS TO THE DIVISION WITH YOUR APPLICATION FOR LICENSURE.

Physician Assistant Name: _____

Supervising Physician Name: _____

Utah License Number: _____

Substitute Supervising Physician(s):

Name: _____ Utah License Number: _____

Name: _____ Utah License Number: _____

Name: _____ Utah License Number: _____

Name: _____ Utah License Number: _____

PRACTICE SITE(S):

1. Name of Facility: _____

   Address: _____

   City: _____ State: _____ Zip: _____

2. Name of Facility: _____

   Address: _____

   City: _____ State: _____ Zip: _____

DEGREE AND MEANS OF SUPERVISION:

The supervising physician shall provide supervision to the physician assistant to adequately serve the health care needs of the practice population and ensure that the patient's health, safety, and welfare will not be adversely compromised. There shall be a method of immediate consultation by electronic means whenever the physician assistant is not under the direct supervision of the supervising physician. A physician assistant holding a temporary license may work only under 100% direct supervision. There shall be a method of immediate consultation by electronic means whenever the physician assistant is not under the direct supervision of the supervising physician.

FREQUENCY AND MECHANISM OF CHART REVIEW:

The degree of onsite supervision shall be outlined in the Delegation of Services Agreement maintained at the site of practice. Physician assistants may authenticate with their signature any form that may be authenticated by a physician signature.

PRESCRIBING OF CONTROLLED SUBSTANCES:

A physician assistant may prescribe or administer an appropriate controlled substance if the physician assistant holds a current Utah controlled substance license covering the appropriate schedules of controlled substances and a current DEA registration covering the appropriate schedules of controlled substances; the prescription or administration of the controlled substance is within the prescriptive practice of the supervising physician and also within the delegated prescribing stated in the delegation of services agreement; and the supervising physician co-signs any medical chart record of a prescription of a Schedule 2 or Schedule 3 controlled substance made by the physician assistant.

In order to prescribe controlled substances, the physician assistant must have obtained his or her own controlled substance license and DEA registration. The physician assistant may not use his or her supervising physicians' controlled substance licenses or DEA registrations.

PROCEDURES ADDRESSING SITUATIONS OUTSIDE THE PHYSICIAN ASSISTANT'S SCOPE OF PRACTICE:

PROCEDURES FOR PROVIDING BACKUP FOR THE PHYSICIAN ASSISTANT IN EMERGENCY SITUATIONS:

_____

_____

_____

_____

_____

_____

_____

ADDITIONAL CONSIDERATIONS RELATING TO OUR PRACTICE:

_____

_____

_____

_____

Signature of Physician Assistant: _____

Date of Signature: _____

Signature of Supervising Physician: _____

Date of Signature: _____

Signature of Substitute Supervising Physician: _____

Date of Signature: _____

NOTE: It is "unprofessional conduct" under the Physician Assistant Practice Act to fail to maintain at the practice site(s) a "Delegation of Services Agreement" that accurately reflects current practices; or to fail to make the "Delegation of Services Agreement" available to the Division for review upon request.

Mail completed form directly to:
NCCPA
157 Technology Pkwy Ste 800
Norcross GA 30092-2913

NCCPA Request and Authorization for Release of Information

Please type or print. Duplicate as needed.

Section 1: Identification

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone: (_____)_____-_____ Social Security Number: _____-_____-_____

Section 2: Exam Information

Indicate for which exam and examination period you're requesting information. (Only one request per form.)

PANCE (Physician Assistant National Certifying Exam)

PANRE (Physician Assistant National Recertifying Exam)

Pathway II

Surgery Exam

Year: _____ Spring Fall

Section 3: Information Request

Indicate the nature of this request and the person or agency to whom it should be sent.

Eligibility letter, verifying that you are eligible for and registered to take the above exam

Pending letter, verifying that you have taken the above exam and are waiting scores

Exam results

(Complete only if different from above.)

Name: _____

Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Want us to send the information via fax? If so, please provide the fax number here: (_____) -_____

Section 4: Signature and Authorization

Each state licensing authority sets its own rules and regulations. NCCPA strives to stay up-to-date on individual state regulations. We will send the required information, which may consist of current scores and/or score history, to the agency listed above in accordance with the information on state requirement on file with NCCPA.

I acknowledge that I read and understand the above statement and authorize NCCPA to release all information required by the agency listed above.

. _____ _____

(signature) (date)